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Supreme Court, U.S.
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No. 93-1045

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1993

JEWISH MEMORIAL HOSPITAL, et al.
Petitioners,
v.
COMMONWEALTH OF MASSACHUSETTS, et al.
Respondents.

On Petition for Writ of Certorari
to the Supreme Judicial Court
of Massachusetts

RESPONDENTS' BRIEF IN OPPOSITION

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ISSUES PRESENTED

Whether federally-approved Massachusetts regulations requiring utilization control procedures for Medicaid-funded services in chronic hositals are consistent with utilization review requirements prescribed by Title XIX of the Social Security Act.

PARTIES TO THE PROCEEDNGS

The parties to the proceedings are accurately listed in the petition for certiorari at pp. 1-3.

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RESPONDENTS' BRIEF IN OPPOSITION

Pursuant to Supreme Court Rule 15, Respondents submit this brief in opposition to the petition for writ of certiorari ("Pet.").

DECISIONS BELOW

The opinion of the Supreme Judicial Court for the Commonwealth of Massachusetts ("SJC") is reported at 416 Mass. 132, 617 N.E.2d 598 (1993), and is reproduced at pp. A1-A29 of the appendix to the petition ("Pet. App."). The SJC's rescript is reproduced at p. A1 of the appendix to this brief in opposition ("Opp. App."). The decision of the Superior Court is not reported.

JURISDICTION

The opinion and order of the Supreme Judicial Court were entered on August 11, 1993. The SJC denied a Petition for Rehearing on September 23, 1993. The petition was filed on December 21, 1993, and was received by Respondents on the same day. The petitioners invoke the

Court's jurisdiction pursuant to 28 U.S.C. § 1257(a). Respondents contend that this Court lacks jurisdiction because the decision of the SJC is not a final judgment.

RELEVANT STATUTORY AND REGULATORY PROVISIONS

The text of the relevant statutory and regulatory provisions is accurately set forth in the appendix to the petition, Pet. App. A32-A61, with two minor exeptions not material to the issues on which review is sought.1/

1/ The two errors are as follows:
At Pet. App. 55, "1902(a)(44)" should read "1396a(a)(44)."
At Pet. App. 32, part (A), "100 C.M.R. 435.000" should read "106 C.M.R. 435.000."

STATEMENT OF THE CASE

An accurate statement of the case appears in the opinion of the Supreme Judicial Court of Massachusetts, at Pet. App. A2-A7. However, the opinion does not fully describe the challenged regulations, and the petition mischaracterizes the regulations.[2/]

The challenged regulations concern operation of the Massachusetts Medicaid

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[2/] The petition repeatedly asserts contentions regarding the effects of the regulations on decisions regarding patient care and placement, relying for these assertions on what it describes as uncontroverted physician affidavits contained in the state court record. The affidavits relied on merely assert the plaintiff physicians' misinterpretation of the challenged regulations, not factual matters within the affiants' personal knowledge. Accordingly, the state courts properly gave them no weight.

program, pursuant to Title XIX of the Social Security Act and the Commonwealth's Medicaid Plan, which has been approved by the Secretary of Health and Human Services. As will be explained more fully infra, the specific regulations in issue here have also received approval from the Secretary through the Health Care Financing Administration ("HCFA").

The challenged regulations have two principal effects: First, they require compliance with a pre-admission screening procedure as a condition of Medicaid reimbursement for chronic hospital services. Second, they establish new level-of-care criteria for determination of the appropriateness of chronic hospital placement.

Pre-admission screening is a process by which reimbursement for in-patient services is conditioned on advance approval of the admission by the entity providing reimbursement, or by some screening agency acting for it. Over the past decade, pre-admission screening has become routine among non-governmental third party payers, such as insurance carriers and health maintenance organizations. Feldstein, P., et al., Private Cost-Containment: The Effects of Utilization Review Programs on Health Care Use and Expenditures, 318 New Eng. J. Med. 1310,

1311 (1988).[3]

The Massachusetts Medicaid program implemented a pre-admission screening requirement for acute-care hospitals in February of 1988, see 106 C.M.R. § 450.207 (Rev. 8/1/90). The program has also required pre-admission screening for child psychiatric hospitals since approximately 1985 (R.A. 519-523).[4]

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[3] HCFA began to institute a pre-admission screening program for both Medicare and Medicaid in 1975; implementation of that program was barred temporarily by a preliminary injunction, but that injunction was vacated and the case dismissed upon HCFA's agreement to make certain changes in the requirements of the program. American Medical Association v. Weinberger, 522 F.2d 921 (7th Cir. 1975); see 42 C.F.R. Ch. IV (10-1-89 Edition), at 250-1 & n.1.

[4] References to the record appendix filed with the SJC are denoted herein as "R.A. __".

Similar prior approval requirements have applied to nursing home placements since at least 1981. See Mass. St. 1981, c. 351, § 186. Indeed, until the challenged regulations took effect on March 1, 1991, chronic and rehabilitation hospitals were the only type of institutional provider of Medicaid services in Massachusetts that were not subject to pre-admission screening. The regulations in issue here extended this requirement, already in place for others, to this one remaining category of institutional provider.5/

5/ Specified outpatient services have also required advance approval since as early as 1969. Mass. Gen. L. c. 118E, § 7, enacted by Mass. St. 1969, c. 800, § 1.

The regulations describe the process for obtaining pre-admission approval. Hospitals which meet specified requirements for "Delegated Status" are authorized to conduct the screening themselves; in these instances, Medicaid staff are required to authorize payment based solely on the hospital's own determination. 106 C.M.R. § 435.401(B)(1). Other hospitals are required to notify the Medicaid agency[6/] of the impending admission. 106 C.M.R. § 435.401(B)(2). A Department staff nurse then makes an initial determination of whether the patient meets the applicable level-of-care criteria; if so the nurse

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6/Formerly the Department of Public Welfare, now the Division of Medical Assistance.

authorizes payment. 106 C.M.R. § 435.401(B)(2)(b).

If the initial determination is negative, the nurse is required to contact the hospital for any additional information available. 106 C.M.R. § 435.401(B)(3). If the determination remains negative at this point, the nurse "shall refer the case for physician reconsideration upon the patient's request." 106 C.M.R. § 435.401(B)(3). That reconsideration is to be conducted "between the Department's nurse and the recipient's physician" (emphasis added). 106 C.M.R. § 435.401(B)(3). If the two still disagree, "an independent physician, in the same practice specialty as the attending physician, shall decide, utilizing the principles of medical peer

review." 106 C.M.R. § 435.401(B)(3); A19 (SJC opinion). In case any conceivable doubt remains, the regulation goes on to state that, "[a] final determination of non-coverage will be made only by a physician." Such negative determinations, moreover, trigger procedures for notice and administrative appeal. 106 C.M.R. § 435.409(B).

The level-of-care criteria established at 106 C.M.R. § 435.409 serve as the substantive standards governing pre-admission screening. That is, these criteria describe the circumstances under which a patient is considered to need care at a hospital level, as opposed to out-patient or in a nursing home or other facility.

Massachusetts Medicaid regulations have established level-of-care criteria for hospital services since 1977 (R.A. 518). See Norfolk County Hospital v. Commmonwealth, 25 Mass. App. Ct. 586, 591, 521 N.E.2d 406, 409 (1988) (upholding earlier level-of-care criteria for chronic hospitals); Pet. App. 14 (SJC opinion). With respect to these criteria, the regulatory amendments in issue here do not establish a new program, or abolish any existing program. These amendments do, however, make certain changes in the criteria themselves, primarily to bring them into closer conformity with criteria applicable under the Medicare program.

Under the Medicare statute, 42 U.S.C. § 1395x(k) (1988), all in-patient

hospital services are subject to utilization review for medical necessity by a Peer Review Organization. See also 42 C.F.R. §§ 412.44, 466.70-71 (1990). As the Petitioners themselves admitted in affidavits submitted to the Superior Court, the Peer Review Organizations base those determinations on application of the Adult Appropriateness Evaluation Protocol ("AEP") (R.A. 15, 93, 99, 108, 119, 129, 139, 142, 180).

The AEP is an "objective criteria-based system for the determination of appropriateness of hospital days of care." Gertman, P., and Restuccia, J.; The Appropriateness Evaluation Protocol: A Technique for Assessing Unnecessary Days of Hospital Care, XIX Med. Care 855, 857 (August

1981). The AEP consists of a set of criteria in three categories: medical services, nursing/life support services, and patient condition factors. Id. at 857. Under the AEP, a patient who meets any of the criteria is considered to be appropriately hospitalized. Id. In addition to the specified objective criteria, the AEP includes "a system of 'overrides,'" which allow a determination, based on individualized physician judgment, that hospitalization is appropriate despite the absence of any listed criteria. Id. at 858. The AEP was "developed by Boston University researchers working in consultation with physicians in Massachusetts professional standards review organizations." Siu, A., et al., Inappropriate Use of

Hospitals in a Randomized Trial of Health Insurance Plans, 315 New Eng. J. Med. 1259, 1260 (1986). The AEP has been repeatedly tested and validated in published professional studies, and has been found to be "a valid and reliable instrument." Id. at 1260, and sources cited.7/

The criteria set forth in the regulations do not, however, require determinations based on a mechanical application of the AEP. Rather, 106 C.M.R. § 435.409(A) provides that the AEP is to be used "as a guide" in the

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7/ Because of the system of overrides, the fact that development and testing of the AEP has focused on acute hospitals does not make its use for chronic hospital admissions inappropriate. Rather, this fact means only that physician review will be required more frequently than might be the case if a more specifically targeted protocol were used.

determination of whether the patient meets the criteria specified at §§ 435.409(1) and (2). Moreover, since the AEP itself provides for flexibility, that very flexibility is incorporated in its use under the regulations. Thus, to the extent that the AEP itself authorizes overriding of its specific criteria based on physician judgment with respect to a particular patient's circumstances, the regulation incorporates that authorization.

The regulatory criteria themselves, 106 C.M.R. §§ 435.409(1) and (2), are broad and flexible. In essence, the test is whether the patient needs services of a type that "in light of the recipient's medical condition," cannot be provided in a lower level setting.

106 C.M.R. § 435.409(A)(1)(b). In addition, the patient must be in need of either "daily or more frequent physician supervision," or "constant availability of medical services and equipment ordinarily available only in a hospital setting." 106 C.M.R. § 435.409(A)(1)(c). Thus, a patient whose condition is so unstable as to pose a risk of rapid deterioration would qualify based on a need for constant availability of physician response, even without an ongoing need for daily physician supervision. Finally, 106 C.M.R. § 435.409(A)(2) provides a catch-all alternative, authorizing admission, even absent the other criteria, when chronic hospital placement "is more cost-effective" than

alternatives, and "the recipient's complex medical condition prevents an alternative placement."

The regulations do not purport to govern determinations of the medical necessity of any treatment or procedure provided to any patient. Such determinations are left entirely to physicians. Rather, the regulations merely ensure that whatever treatment physician judgment determines to be necessary is delivered in the most cost-effective setting. Pet. App. 12-13 (SJC opinion).

Under regulations that pre-date these changes, the level-of-care criteria serve a second function, in addition to their role as substantive standards for pre-admission screening.

Under 106 C.M.R. § 435.412, each hospital is required to engage in a continuous process of utilization review ("UR"), applying the level-of-care criteria. UR, which federal law also requires, is the examination of utilization records, by the hospital's own medical staff or by the Peer Review Organization ("PRO"), to determine the appropriateness and medical necessity of hospital services being provided or already provided. See, e.g., 42 U.S.C. § 1395x(k)(3) (review "to be made as promptly as possible, after each day so specified [in regulations], and in no event later than one week following such day"). Among other consequences, UR can result in determinations that some part of a patient's hospital stay is

reimbursable not at the hospital's regular rate, but at a lower rate designated for "Administratively Necessary Days" ("AND's"). 106 C.M.R. § 435.413 and 414.[8/] Nothing in these amendments changes the UR process, or its implications for reimbursement at AND rates, or the fact that UR is conducted by the hospitals' own staff or the PRO, in accord with the level-of-care criteria set in these regulations. Pet. App. 20 (SJC opinion).

During the course of its consideration of the regulations now under challenge, the Massachusetts

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[8/] For reasons specific to state law and not relevant here, the application of AND rates does not actually decrease Medicaid reimbursement to chronic hospitals in Massachusetts. See Youville Hospital v. Commonwealth, 416 Mass. 142, 145, 617 N.E.2d 605, 607 (1993).

Department of Public Welfare engaged in a series of correspondence with HCFA regarding the relationship between the regulations and applicable federal law. Petitioners also participated in this process, expressing their objections to the regulations, including the arguments presented in the petition, in a series of letters from their counsel to HCFA. In a letter dated December 21, 1990, HCFA's Associate Regional Administrator expressed approval of the regulations, indicating that nothing in them supplied a basis for any compliance action against the Commonwealth (R.A. 543). The letter went on to comment that:

> We want to reiterate that the State Medicaid agency may place appropriate limits on coverage of services based on such criteria as medical necessity and utilization control

> procedures, and that the State Medicaid agency should not cover services that it considers to be medically unnecessary, or medically unnecessary in a particular setting. The State Medicaid agency has some latitude in this regard, and we show appropriate deference to the State agency's judgments in these matters insofar as they are not contrary to the specific requirements of Title XIX.

(R.A. 543).

REASONS FOR DENYING THE WRIT

"A review on writ of certiorari is not a matter of right but of judicial discretion." Sup. Ct. R. 10.1. Such a writ is granted "only when there are special and important reasons therefor." Id. The purpose of certiorari jurisdiction is to permit the Court to select cases of "such gravity and general importance" as to warrant

plenary review. In re Woods, 143 U.S. 202, 206 (1892).

For the reasons set forth below, the petition does not satisfy the traditional criteria which guide the Court's discretionary review. Accordingly, the petition should be denied.

I. THIS COURT LACKS JURISDICTION BECAUSE THE DECISION OF THE SUPREME JUDICIAL COURT IS NOT A FINAL JUDGMENT.

The order of the Supreme Judicial Court directed that the case be "remanded for consideration of such issues in the complaint that were not decided by the declaratory judgment," and that "the declaratory judgment shall be supplemented and amended to be consistent with this opinion and to resolve any undecided issues as to which

there is an actual controversy" (A1). Thus, the SJC's decision has not ended the case, but only moved it to its next stage, which will occur in the Massachusetts Superior Court, subject thereafter to appellate review once again.

Even with respect to the particular issues decided by the SJC, including the federal issue presented in the petition, the judgment to be entered is not yet established, since the SJC has directed that the declaratory judgment be amended. Moreover, as the SJC explained in its opinion, because the judgment it reviewed did not dispose of the entire case, it was not final and thus technically not appealable; the SJC considered the issues raised pursuant to

its discretionary authority under state law. Pet. App. 6-7 (SJC opinion). Thus, the SJC's decision is not a "final judgment" subject to review in this Court under 28 U.S.C. § 1257. See Collins v. Miller, 252 U.S. 364, 370 (1920).

II. THE PETITION PRESENTS NO GROUND FOR REVIEW UNDER THE CRITERIA SET FORTH IN RULE 10 OF THIS COURT'S RULES.

The Petition does not even purport to set forth a basis for review under Rule 10 of this Court's rules. It does not contend that the SJC has decided a federal question in conflict with another state's highest court or with a United States Court of Appeals, nor does it contend that the SJC has decided an important question of federal law that should be settled by this Court, or has

decided such a question in conflict with a decision of this Court. Rather, petitioners' contention, in essence, is nothing more than that the SJC decision is wrong. That claim presents no special or important reason for review. Sup. Ct. R. 10; See Hamilton Shoe Co. v. Wolf Bros., 240 U.S. 251, 258 (1916); In re Woods, 143 U.S. at 206.

Indeed, the Petition cites no decisions of this or any federal court, or of any state court, addressing the federal question it purports to raise: whether the particular federal statutory provisions on which petitioners rely bar a state Medicaid agency from conditioning hospital reimbursement on compliance with regulations mandating pre-admission screening and setting

level-of-care criteria. That question can hardly be considered of such inherent importance as to warrant resolution by this Court in the absence of any indication of conflict among lower courts.

The closest the petition comes to invoking the criteria of Rule 10 is its assertion that the SJC decision conflicts with Blum v. Yaretsky, 457 U.S. 991 (1982) (Pet. 27). That assertion rests on a misreading of both decisions.

This Court's holding in Blum v. Yaretsky addressed the issue of whether a nursing home's implementation of state utilization control regulations was state action subject to the fourteenth Amendment. 457 U.S. at 993, 1002-3,

1005, 1012. Blum did not purport to construe the Social Security Act, still less the particular provisions on which petitioners here rely; its references to the operation of provisions of that statute were by way of background to present the context in which the state action question arose.

Furthermore, the claimed inconsistency evaporates on reading of the SJC's decision, which, in contrast to the petition's distorted paraphrase, in no way departs from Blum's description of the Medicaid program. The petition, at p. 27, quotes part of a sentence from the SJC's opinion, misstates the remainder of the passage, and thus presents a purported distinction that the SJC never made. The SJC's actual language was as follows:

> The challenged regulations concern the question whether a placement in a chronic disease hospital is appropriate for reimbursement purposes. The statutory language concerns the determination of the medical necessity for care in such a hospital.

(Pet. App. 12)

The SJC's distinction was not, as petitioners' contend, between placement for medical necessity purposes, and placement for reimbursement purposes; the distinction, rather, was between placement and "care" -- i.e., between the decision as to the facility in which services are rendered, and the decision as to what services are to be rendered to a patient. Thus the SJC's decision in no way conflicts with Blum's recitation of the requirement that medically necessary services, and only

those services, be reimbursed under Medicaid.

Moreover, the SJC's discussion in which this language appears did not relate to the federal question on which petitioners seek this Court's review. Rather, the quoted language related to a wholly state law issue petitioners had presented to the state courts: that is, whether the regulations were inconsistent with a state statute, Mass. St. 1988, c. 270, § 1, regarding the process by which "determinations of the medical necessity of care" are to be made. Thus, the SJC construed the word "care," as used in that statute, and distinguished it from placement, which the challenged regulations address. The SJC's ruling on this state law question

has no bearing on the federal issue presented for review, and in no way conflicts with Blum.

III. THE SJC CORRECTLY HELD THE REGULATIONS, WHICH HCFA HAS APPROVED, CONSISTENT WITH THE SOCIAL SECURITY ACT

Under both federal and state law, Medicaid reimbursement is limited to services that are "medically necessary," and that are rendered in an appropriate setting. 42 U.S.C. § 1396a(a)(30)(A)(1988); 42 C.F.R. § 440.230(d)(1990); Mass. Gen. L. c. 118E, § 6; 106 C.M.R. § 450.204; See Blum v. Yaretsky, 457 U.S. at 994. If the care needed by a particular patient can be provided in a non-hospital setting, then hospitalization of that patient is not reimbursable. See 42 C.F.R. § 466.86(a)(3).

This limitation is of particular fiscal significance; Congress has recognized the extremely high cost of inpatient hospital services, as compared with care in nursing homes and other less intensive settings. S. Rep. No. 404, 89th Cong., 1st Sess. (1965), reprinted in 1965 U.S.C.C.A.N. 1943, 1987 (patients should remain in hospitals only as long as necessary, moving to other facilities that "provide less expensive, but equal, care").

Federal law requires the state Medicaid agency to ensure compliance with the requirements of both medical necessity of services and appropriateness of setting. E.g., 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 456.1. The federal scheme requires

the state to "safeguard against unnecessary utilization of such care and services," through the use of methods "including but not limited to utilization control plans." 42 U.S.C. § 1396a(a)(30)(A). Under federal law, if HCFA were to determine that the Commonwealth had failed to meet the requirement of limiting reimbursement to medically necessary services, it could deny federal reimbursement for those expenditures. 42 U.S.C. § 1396b(a)(1) (1988).

Petitioners rely on 42 U.S.C. § 1396b(i)(4), which prohibits federal reimbursement for payments to any facility "unless such hospital or skilled nursing facility has in effect a utilization review plan which meets the

requirements imposed by § 1395x(k) of this title." On its face, this provision limits Medicaid reimbursement to hospitals that conform to the utilization review ("UR") requirements of the Medicare program. As the SJC held, Pet. App. 20, the statute does not prohibit states from imposing any additional requirements that are compatible with Medicare UR standards. Most importantly, the statute says nothing whatever about pre-admission screening.

The Medicare standards referred to appear at 42 U.S.C. § 1395x(k). That statute provides that a hospital UR plan "shall be considered sufficient" if it meets the specified requirements. Nothing in § 1395x(k) limits hospitals

from adopting additional UR or other utilization control procedures, nor does the statute in any way prohibit states from conditioning reimbursement on hospitals' compliance with additional procedures. The regulations challenged here in no way impede hospitals' compliance with the federal requirement. Rather, the regulations merely add the additional, fully compatible step of pre-admission screening to the overall utilization control system.

Any doubt that may remain as to the consistency between the regulations and federal law should be resolved on the basis of HCFA's determination that the two are fully consistent (R.A. 543-44). The Court should give weight to this

interpretation of the federal scheme by the agency charged with enforcing it. Miller v. Youakim, 440 U.S. 125, 144 (1979); Rosado v. Wyman, 397 U.S. 397, 406-407 (1970).

CONCLUSION

For the foregoing reasons, this Court should deny the petition.

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Dated: January 20, 1994

WPPJF2/381

COMMONWEALTH OF MASSACHUSETTS

Supreme Judicial Court
for the Commonwealth

At Boston

August 11, 1993

IN THE CASE No. SJC 6226

JEWISH MEMORIAL HOSPITAL & others

v.

COMMONWEALTH & others.

pending in the Superior Court Department of the Trial Court for the County of Suffolk No. 90-7114

The case is remanded for consideration of such issues in the complaint that were not decided by the declaratory judgment. In the judge's discretion, the complaint may be amended to present current issues. The declaratory judgment shall be supplemented and amended to be consistent with this opinion and to resolve any undecided issues as to which there is an actual controversy.

By the Court,

s/Susan Mellen, Ass't Clerk

August 11, 1993

See opinion on file.